TRICARE Prime And TRICARE Select Referrals/ Preauthorizations/Authorizations

1.0 REFERRALS

1.1 A referral addresses the issue of who will provide authorized health care services. In many cases, TRICARE Prime beneficiaries will be referred by a Primary Care Manager (PCM) to a medical department of a Military Treatment Facility (MTF) if the type of care needed is available at the MTF. In such a case, failure to adhere to that referral will result in the care being subject to Point Of Service (POS) charges. In other cases, a referral may be to the civilian provider network, and again, POS charges would apply to a failure to follow the referral. In contrast to referral, preauthorization (see Chapter 7, Section 2) addresses the issue of whether particular services may be covered by TRICARE, including whether they appear necessary and appropriate in the context of the patient's diagnosis and circumstances. A major purpose of preauthorization is to prevent surprises about coverage determinations, which are sometimes dependent on particular details regarding the patient's condition and circumstances. While TRICARE Prime has referral requirements that do not exist for TRICARE Select, TRICARE Select has some preauthorization requirements that do not exist for TRICARE Prime.

1.2 For referrals requiring contractor authorization, the contractor shall review the referral request, to determine.

- That the provider to whom the patient is referred meets applicable authorized provider and network provider requirements,
- That the services being requested are a TRICARE covered benefit and are requested in a covered setting, and
- Whether any specific services requested as part of the referral also require preauthorization.

The contractor shall provide a response to the referring provider and beneficiary. The response shall identify any requested provider and/or services that are excluded from coverage and the reason(s) therefore, and will either not be paid by TRICARE, or paid under the POS option, if applicable. A preauthorization based on a contractor's medical necessity or utilization management determination is not required when a network PCM or network specialty care provider makes a referral to a network specialty care provider except as required under Chapter 7, Section 2. For additional information on TRICARE Prime access standards for enrollees, see 32 CFR 199.17(p)(5).

1.3 The TRICARE beneficiary must be "held harmless" (i.e., considered not financially responsible for any charges) in cases where the network provider fails to request a referral and the contractor

either denies payment or applies the POS option. If the referral involves services rendered by a non-network provider, "hold harmless" cannot apply, as "hold harmless" only applies to network providers. Once the patient is evaluated by the specialist, the contractor may require an authorization before the services are provided or the procedure performed. In those instances where a contractor requires authorization of services in addition to those listed in Chapter 7, Section 2, such authorization must be available to and appealable by all beneficiaries, whether enrolled or not. Within Prime Service Areas (PSAs), the MTFs have the Right of First Refusal (ROFR) for all referrals, as determined by the Memorandum of Understanding (MOU) between the contractor and each MTF.

1.4 Urgent Care Referrals

1.4.1 Effective January 1, 2018, contractor approval of referrals for urgent care visits for TRICARE Prime enrollees are no longer required. No referral from their PCM or authorization by a Health Care Finder (HCF) will be required and no POS deductibles and cost shares shall apply when urgent care is provided by a TRICARE network provider or a TRICARE-authorized (network or non-network) Urgent Care Center (UCC) or Convenience Clinic (CC). If the enrollee seeks care from a non-network provider (except a TRICARE-authorized UCC or CC), the usual POS deductible and cost-shares shall apply. This supersedes the guidance in Chapter 18, Section 19 regarding the number of unmanaged urgent care visits for TRICARE Prime enrollees.

Note: The aforementioned January 1, 2018, urgent care referral policy excludes Uniformed Services Family Health Plan (USFHP) enrollees.

1.4.2 ADSMs enrolled in TRICARE Prime continue to need a referral. ADSMs enrolled in TRICARE Prime Remote (TPR) will not be held to any urgent care referral requirement, but they are still held to applicable Department of Defense (DoD) and Service regulations concerning ADSM care outside MTFs. The usual ADSM POS exception stands.

1.4.3 Active Duty Family Members (ADFMs) enrolled in TRICARE Prime may self refer for urgent care but they are required to seek urgent care from a TRICARE network provider or a TRICARE-authorized (network or non-network) UCC or CC. If the enrollee seeks care from a non-network provider (except a TRICARE-authorized UCC or CC), the usual POS deductible and cost-shares shall apply.

1.4.4 ADFMs enrolled in TPRADFM with an assigned Primary Care Provider (PCP) are required to seek urgent care from a TRICARE network provider or a TRICARE-authorized (network or non-network) UCC or CC to avoid POS.

1.4.5 ADFM in TPRADFM without an assigned PCP may utilize any local TRICARE participating or authorized provider for primary care services (to include urgent care services).

1.4.6 ADFMs and ADSMs enrolled to TOP Prime/Prime Remote enrollees need to contact the TOP contractor to obtain an authorization in order to ensure their urgent care visit will be cashless/claimless. Without this authorization, overseas providers may request payment upfront and the beneficiary will then have to submit a claim for reimbursement.

- ADSMs enrolled to TOP Prime/Prime Remote requiring urgent care while Temporary Duty (TDY) or on leave, in the 50 United States and the District of Columbia, will not

be held to any urgent care referral requirement, but they are still held to applicable DoD and Service regulations concerning ADSM care outside MTFs/eMSMs. The usual ADSM POS exception applies.

- ADFMs enrolled to TOP Prime/Prime Remote traveling in the 50 United States and the District of Columbia, may access urgent care without a referral or an authorization, but POS deductibles and cost shares shall apply for claims when urgent care is not provided by a TRICARE network provider or a TRICARE-authorized (network or non-network) UCC.

1.4.7 If urgent treatment is required by a TRICARE Prime enrollee after hours, while traveling away from their residence, or whose PCM is otherwise unavailable, the enrollee may contact their Managed Care Support Contractor (MCSC), TOP contractor, Designated Provider (DP), Nurse Advice Line (NAL) (where available) for assistance finding an appropriate facility/provider before receiving non-emergent care from a provider other than the PCM. If an enrollee is traveling overseas, he or she may call the TOP Regional Call Center for the region in which he or she is traveling to coordinate urgent care.

1.4.8 TRICARE Prime enrollees are to be encouraged to notify their PCM of any urgent/acute care visits to providers other than the PCM within 24 hours of the visit or the first business day following the visit and to schedule follow-up treatment, if indicated, with their PCM or to get a referral from the PCM for additional specialty care. The contractor shall provide beneficiary and provider education on this process, to include information on how to schedule follow-up appointments, and how to coordinate care.

1.4.9 Urgent care can be rendered by a TRICARE network provider or TRICARE-authorized UCC. Providers must have one of the following primary specialty designations:

- Family Practice;
- Internal Medicine; General Practice;
- Pediatrician; and
- UCC or Convenience Clinics (CCs).

Note: In accordance with TPM, Chapter 1, Section 7.1, Obstetricians/Gynecologists (OB/GYNs), Physician Assistants (PAs), Nurse Practitioners (NPs), and Certified Nurse Midwives (CNMs) can be considered Primary Care Providers (PCPs) and may also be designated PCMs.

2.0 PREAUTHORIZATIONS/AUTHORIZATIONS

2.1 The contractor is responsible for reviewing all requests for authorization to determine that the services being requested are a TRICARE benefit. Issuance of authorizations are not a medical necessity or utilization management determination and shall not be used to restrict freedom of choice of the TRICARE Standard (through December 31, 2017) or TRICARE Select (as of January 1, 2018) Select beneficiary who chooses to receive care from authorized non-network providers, except as required under Chapter 7, Section 2. However, when a TRICARE Select beneficiary receives services covered by the basic program benefits from an authorized health care provider who is not part of the TRICARE provider network, that care is covered by TRICARE but is subject to higher cost-sharing amounts for "out-of-network" care.

2.2 The contractor is required to advise beneficiaries, sponsors, providers, and other responsible persons of those benefits requiring authorization before payment may be made and inform them of the procedures for requesting the authorization. Although beneficiaries are required to obtain authorization prior to receiving payment for the care listed at Chapter 7, Section 2, authorization may be requested following the care. Whether the authorization is requested before or after care, all qualified care shall be authorized for payment. The contractor shall emphasize the need for concerned persons to contact a Beneficiary Counseling Assistance Coordinator (BCAC)/Health Benefits Advisor (HBA) or the contractor for assistance.

2.3 Because of the high risk that many services requiring special authorization may be denied, the contractor shall offer preauthorization for the care to all TRICARE beneficiaries who reside within its jurisdiction. The contractor shall process all requests for such authorization whether submitted by the beneficiary, sponsor or provider requesting authorization on behalf of the beneficiary.

2.4 The contractor shall issue notification of preauthorization/authorization or waiver to the beneficiary or parent/guardian or a minor or incompetent adult, the provider, and to its claims processing staff. Notification may be made in writing by letter, or on a form developed by the contractor. These forms and letters are all referred to as TRICARE authorization forms. The contractor shall not issue an authorization for acute, inpatient mental health care for more than seven calendar days at a time.

2.5 The contractor shall document authorizations. The contractor must also maintain an automated authorization file or an automated system of flagging to ensure claims are processed consistent with authorizations. The contractor shall verify that the beneficiary, sponsor, provider, and service or supply information submitted on the claim are consistent with that authorized and that the care was accomplished within the authorized time period.

2.6 Prime enrollees receiving emergency care or authorized care from non-network, non-participating providers shall be responsible for only the Prime copayment. On such claims, contractors shall allow the amount the provider may collect under TRICARE rules; i.e., if the charges on a claim are subject to the balance billing limit (refer to the TRICARE Reimbursement Manual (TRM), Chapter 3, Section 1 for information on balance billing limit), the contractor shall allow the lesser of the billed charges or the balance billing limit (115% of allowable charge). If the charges on a claim are exempt from the balance billing limit, the contractor shall allow the billed charges. Refer to the TRM, Chapter 2, Section 1 for information on claims for certain ancillary services.

2.7 The requirement that a TRICARE Prime enrollee obtain a referral/authorization from their PCM to receive the H1N1 immunization from a non-network, TRICARE-authorized provider has been temporarily waived from October 1, 2009 to May 1, 2010. During this period, Prime enrollees may obtain the H1N1 immunization from a non-network TRICARE-authorized provider without prior authorization or PCM referral. POS cost-shares normally associated with non-referred care obtained by Prime enrollees from non-network providers without appropriate authorization will not apply during this period.

2.8 ADSMs, who have sustained an amputation, shall be considered for transfer or admission to an appropriate MTF/Enhanced Multi-Service Market (eMSM) Center of Excellence. Prior to authorizing rehabilitative treatment to a purchased care sector provider or facility, the contractor (Managed Care Support Contractor (MCSC), DP, and TOP), in coordination with the respective

TRICARE Regional Office (TRO)/TRICARE Area Office (TAO) and the assigned MTF (or Defense Health Agency-Great Lakes (DHA-GL) for TPR enrollees), shall determine whether care is available from any DoD Advanced Rehabilitation Center (ARC). The DoD ARCs include the Center for the Intrepid (CFI); San Antonio Military Medical Center (SAMMC), San Antonio, Texas; Military Advanced Training Center (MATC); Walter Reed National Military Medical Center (WRNMMC), Bethesda, Maryland; and the Comprehensive Combat and Complex Casualty Care (C5), Naval Medical Center, San Diego, California. The assigned MTF (or DHA-GL for TPR enrollees) and the ARC will determine appropriateness of the transfer/referral. If care is available and appropriate in one of these facilities, the contractor shall facilitate the transfer or admission of the ADSM as soon as practical based on the patient's condition. The contractor should coordinate with the respective TRO/TAO or DHA-GL for any issues or concerns. See contract Contract Data Requirements Lists (CDRLs) for reporting requirements.

3.0 FAILURE TO COMPLY WITH PREAUTHORIZATION - PAYMENT REDUCTION

During claims processing, provider payments shall be reduced for failure to comply with the preauthorization requirements for certain types of care. See the TRM, Chapter 1, Section 28, for more information.

4.0 PSYCHIATRIC RESIDENTIAL TREATMENT CENTERS (RTCs)

4.1 Before any claims for RTC care may be paid, an authorization must be on file. The dates of service on the claim form and the name of the facility plus the Employer Identification Number (EIN) with suffix must correspond with the dates of the approval and the facility indicated on the authorization. If the beneficiary resides outside of the contractor's region, the contractor responsible for payment shall pay the claims at the rate determined by the DHA. When the contractor issues an RTC authorization, it shall flag its files to preclude payment of any family or collateral therapy that is billed in the name of the RTC patient. That cost is the responsibility of the RTC, unless, as part of its negotiated agreement, the contractor agrees to a separate payment for such care. Under the DHA-determined rates, family therapists may bill separately from the RTC (outside the all-inclusive rate) only if the therapy is provided to one or both of the parents residing a significant distance from the RTC. In the case of residents of a region, geographically distant family therapy must be certified by the contractor in order for cost-sharing to occur.

4.2 If a claim for admission or extension is submitted and no authorization form is on file, the claim shall not be paid. For network claims, the contractor may deny or develop in accordance with its agreements with network providers. For non-network claims, the contractor shall deny the claim.

4.3 For any claims submitted for inpatient care at other than the RTC, the contractor shall pay the claim if the care was medically necessary. Claims for RTC care during the period of time the beneficiary was receiving care from another inpatient facility shall be denied. If the RTC has been paid and a claim for inpatient hospital care is received and the care was medically necessary, the contractor must pay the inpatient hospital claim and recover the payment from the RTC.

5.0 GRANDFATHERED CUSTODIAL CARE CASES

A list of the beneficiaries who qualified for custodial care benefits prior to June 1, 1977, has been furnished to the contractor with instructions to flag the file for those beneficiaries on the list

who are within its region. Claims received for those beneficiaries, for which no authorization is on file, are to be suspended and the contractor shall notify DHA Communications. Refer to 32 CFR 199.4.

6.0 REFERRAL AND AUTHORIZATION PROCESS

The contractor shall process referrals in accordance with the following:

6.1 Referrals From The MTF To The Contractor

Referral Management Suite (RMS) is the DoD's system to transmit referrals and authorizations between the Military Health System (MHS) MTF and contractors. RMS captures and stores the referral and authorization information allowing for the tracking of referrals from the time it is created to the time the referral results are provided to the referring provider or closed for non-use by the patient. RMS is able to transmit Health Insurance Portability and Accountability Act (HIPAA) compliant 278 Health Care Services Review Request for Review and Response transactions. The RMS supports reporting of referral authorization processing times, rejected referrals, and referrals awaiting contractor response, among others. Faxing shall be used only in situations when electronic means is temporarily unavailable (with the exception of transmission of ROFRs and the Coast Guard which does not use the RMS). Referrals from the MTF will include the information in the chart below, at a minimum, unless otherwise specified. The MTF is not required to provide diagnosis or procedure codes. The contractor shall translate the narrative descriptions into standard diagnosis and procedure codes. The contractor shall ensure that care received outside the MTF and referred by the MTF (for MTF enrollees) is properly entered into the contractor's claims processing system to ensure the appropriate adjudication of claims. To facilitate adjudication of claims, the contractor's claims system shall utilize the UIN, at a minimum, to match claims with referral authorizations.

Note: The new MHS Genesis system that is rolling out to four test MTF sites in 2017 does not follow this UIN numbering sequence. The UIN is purely a sequential number.

REQUIRED DATA ELEMENT*	DESCRIPTION/PURPOSE/USE
Request Date/Time	DD MMM YY hhmm
Request Priority	STAT/24-hour/ASAP/Today/72-hour/Routine
Requester	
Referring Provider Name	Name of PCM/MTF individual provider making request
Referring Provider National Provider Identifier (NPI)	Health Insurance Portability and Accountability Act (HIPAA) NPI - Type 1 (Individual)
Referring MTF	Name of MTF
Referring MTF NPI	HIPAA NPI - Type 2 (Organizational)
PATIENT INFORMATION	
Sponsor Social Security Number (SSN)	
Patient ID	Electronic Data Interchange Patient Number (EDI_PN) (from DEERS) if available
Patient Name	Full Name of Patient (if no EDI_PN available)
Patient Date of Birth (DOB)	Date of Birth (required if patient not on DEERS)
Patient Gender	

REQUIRED DATA ELEMENT*	DESCRIPTION/PURPOSE/USE
Patient Address	Full Address of Beneficiary (including zip)
Patient Telephone Number	If available - Telephone Number (including area code)
CLINICAL INFORMATION	
Patient Primary Provisional Diagnosis	Description
Reason for Request	Sufficient Clinical Info to Perform Medical Necessity Report (MNR)
SERVICE	
Service 1 - Provider	Specialty of Service Provider
Service 1 - Provider Sub-Specialty	Additional Sub-Specialist Info if Needed (Free Text Clarifying Info Entered with Reason for Request) e.g., Pediatric Nephrologist
Service 1 - By Name Provider Request if Applicable - First and Last Name	Optional Info Regarding Preferred Specialist Provider (Free Text)
Service 1 - Service Type	Inpatient, Specialty Referral, Durable Medical Equipment (DME) Purchase/Rental, Other Health Service, et al DME Provider to do Certificates of Medical Necessity (CMN)
Service 1 - Service Quantity (optional)	Number of Visits, Units, etc.
Composite Health Care System (CHCS) Generated Order Number (Defense Medical Information System (DMIS)-YYMMDD-XXXXX)	Unique Identifier Number (UIN). The UIN is the DMIS (of the referring facility identified in the "Referring MTF" field on this request) --Date in format indicated-- Consult Order Number from CHCS.
Special Instructions:	
Note 1: *Above data elements are required unless otherwise noted as "Optional."	
Note 2: Use of the NPI is required in accordance with Health and Human Services (HHS) NPI Final Rule by May 23, 2007 or upon service direction and/or direction of the Contracting Officer (CO). Implementation requirements may be found at Chapter 19, Section 4.	
Note 3: When issuing a preauthorization for an ADSM while in terminal leave status to obtain medical care from the Department of Veterans Affairs (DVA)/Veterans Health Administration (VHA), as required by Chapter 17, Section 1, paragraph 4.6, the MTF shall make special entries for data elements as follows:	
Patient Primary Provisional Diagnosis	Condition of a routine or urgent nature as specified by the patient at a future date.
Reason for Request	Provide preauthorization for outpatient treatment by the DVA/VHA for routine or urgent conditions while the active duty patient is in a terminal leave status.
Service 1 - Provider	Any DVA/VHA provider.
Service 1 - By Name Provider Request if Applicable - First and Last Name	DVA/VHA provider only.
Note 4: When issuing an authorization for the DVA/VHA to provide a Compensation and Pension (C&P) examination for a service member as required by Chapter 17, Section 2, paragraph 3.2.2, the MTF shall make special entries for data elements as follows:	
Patient Primary Provisional Diagnosis	V68.01 - Disability Examination or Z02.71 - Disability Examination
Reason for Request	DVA/VHA only: Integrated Disability Evaluation System (IDES) C&P Examinations for Fitness for Duty Determination
Service 1 - Provider	Any DVA/VHA Provider
Service 1 - By Name Provider Request if Applicable - First and Last Name	DVA/VHA Provider Only
Service 1 - Service Quantity	Number of C&P Examinations Authorized

REQUIRED DATA ELEMENT*	DESCRIPTION/PURPOSE/USE
Special Instructions:	
This blanket preauthorization is only for routine and urgent outpatient primary medical care provided by the DVA/VHA while the patient is in a terminal leave status. Terminal leave for this patient concludes at midnight on DD MM YY. The referral in Note 4 shall be considered a blanket authorization for any DVA/VHA provider to conduct the authorized number C&P exams and associated ancillary services.	

6.1.1 Using the UIN, the contractor shall use the CHCS generated order number (DMIS-YYMMDD-XXXXX) as a unique identifier. The first four digits of the UIN is the DMIS of the referring facility only. Using the unique identifier, the contractor will locate related referrals, authorizations, and claims. Contractor generated MTF reports shall be modified to accommodate the unique identifier and NPI as needed. The unique identifier shall also be used for all related customer service inquiries. UINs and NPIs will be attached to all MTF referrals and will be portable across all regions of care. The contractor shall capture the NPIs from the referral transmission report and forward the NPI to the referred-to provider on all referrals.

6.1.2 The MCSC where care is rendered will apply their best business practices when authorizing care for referrals to their network and will retain responsibility for managing requests for additional services or inpatient concurrent stay reviews associated with the original referral as well as changes to the specialty provider identified to deliver the care. The MCSC authorizing the care shall forward the referral/authorization information, including the range of codes authorized (i.e., Episode Of Care (EOC)) and the name, the NPI, and demographic information of the specialty provider to the MCSC for the region to which the patient is enrolled. If the patient is enrolled overseas, the MCSC will provide the same service and information required above to the TOP contractor. If a CONUS Prime retiree/retiree family member receives authorization to obtain care overseas from an MCSC, the MCSC shall forward the authorization information to the TOP contractor to ensure appropriate adjudication of the claim. Claims submitted by the provider will be processed by the MCSC or the TOP contractor according to Chapter 8, Section 2.

6.1.3 The contractor shall screen the information provided and return, by fax or other electronic means acceptable to the MTF and the MCSC, incomplete requests within one business day. The return of a referral to the MTF is considered processed to completion. One business day is defined as the work day following the day of transmission at the close of business at the location of the receiving entity. A business day is Monday through Friday, excluding federal holidays.

6.1.4 The contractor shall verify that the services are a TRICARE benefit through appropriate review to ensure that the service requested is reimbursable through TRICARE. The contractor's medical review shall be in accordance with the contractor's best business practices. This process does not alter the TRICARE Operations Manual (TOM), TRICARE Policy Manual (TPM), or TRICARE Systems Manual (TSM) provisions covering active duty personnel or TRICARE For Life (TFL) beneficiaries.

6.1.5 The MCSC shall advise the patient, referring MTF, and receiving provider of all approved referrals. The MTF single Point Of Contact (POC) shall be advised via fax or other electronic means acceptable to the MTF and the MCSC. (The MTF single POC may be an individual or a single office with more than one telephone number.) The notice to the beneficiary shall contain the unique identifier and information necessary to support obtaining ordered services or an appointment with the referred to provider within the access standards. The notice shall also provide the beneficiary with instructions on how to change their provider, if desired. If the MCSC is made aware the

beneficiary changed the provider listed on the referral, the MCSC will make appropriate modifications to MTF issued referral (to revise the provider the beneficiary was referred to by the MTF). The revised referral shall contain the same level of data as the initial MTF referral. The revised referral will be issued to the current provider, with a copy to the MTF. For same day, 24-hour, and 72-hour referrals no beneficiary notification shall be issued. The MCSC shall notify the provider to whom the beneficiary is being referred of the approved services, to include clinical information furnished by the referring provider.

6.1.6 If services are denied, the MCSC shall notify the patient and shall advise the patient of their right to appeal consistent with the TOM. The MCSC shall also notify the referring single MTF POC by fax of the initial denial.

6.1.7 For services beyond the initial authorization, the MCSC shall use its best practices in determining the extent of additional services to authorize. The MCSC shall not request a referral from the MTF but shall provide the MTF, through the MTF's single POC, a copy of the authorization and clinical information that served as the basis for the new authorization.

6.1.8 Directed Referrals (CONUS Only)

6.1.8.1 The MCSC is responsible for establishing and maintaining an adequate network (Chapter 5, and TRM, Chapter 1, Section 1) to produce the best quality and outcomes for TRICARE beneficiaries. MTF directed referrals could impede the MCSC's ability to maintain and manage the network. Directed referrals are any provider generated by-name request for services. Directed referrals are expected to be rare; however, a description of appropriate circumstances is outlined in the MOU and the process for submitting directed referrals for services within the PSA will be contained within the MOUs between the MTFs, eMSMs, TRO, and MCSC.

6.1.8.2 MTF directed referrals for initial services to a non-network provider greater than 100 miles from the MTF where specialized treatment, surgical procedure, and/or inpatient admission is expected or being requested require justification from the MTF to the MCSC and coordination between the MCSC and TRO prior to approval by the MCSC. This coordination process is contained within the MOUs between the MTFs, eMSMs, TRO, and MCSC. The MOU will also contain guidance on types of MTF directed referrals excluded from this policy. The MCSC will accomplish benefit review and medical necessity review as required by policy and then coordinate with the TRO prior to completing the referral/authorization. MCSC may ask the TRO for guidance on any MTF or network provider directed referral that meets the intent of this policy.

6.1.8.3 The MCSC will make and document appropriate determinations considering the justification provided by the MTF for directed referrals to non-network providers. The MCSC shall track and report MTF-directed referrals to the TRO as specified in the corresponding CDRL.

6.2 Referrals From The Contractor To The MTF

Referrals subject to the ROFR provision from the civilian sector shall be processed as follows:

6.2.1 The MCSC shall fax, or send via other electronic means acceptable to the MTF and MCSC, the referral to the single MTF POC. The request shall contain the minimum data set described in paragraph 6.1 (with the exception of the UIN) plus the civilian provider's fax number, telephone number, and mailing address. This data set shall be provided to the MTF in plain text with or

without diagnosis or procedure codes. This transmission will generally take place within one business day. A business day is Monday through Friday, excluding Federal holidays.

6.2.1.1 Referrals to the MTF shall be classified as follows:

6.2.1.1.1 Urgent referrals are those that must be accepted or declined by the MTF within 90 minutes. If the MTF fails to respond within that time period, the referral is considered a passive denial and the patient is directed to the network by the MCSC.

6.2.1.1.2 Routine referrals are those that must be accepted or declined by the MTF within two business days. If the MTF fails to respond within that time period, the referral is considered a passive denial and the patient is directed to the network by the MCSC.

6.2.2 The MTF will respond via fax or other electronic means acceptable to the MTF and the MCSC as defined in paragraph 6.2.1, to the single POC provided in the MOU by the MCSC. When no response is received from the MTF within the time frames specified above, the MCSC shall process the referral request as if the MTF declined to see the patient. The MCSC shall provide each MTF with a report of the number of referrals forwarded based on the ROFR provision.

6.2.3 ROFR requests will be forwarded for Prime beneficiaries if the MTF has indicated the desire to receive referral request based on specialty or selective diagnosis code or procedure codes, and/or enrollment category. ROFR requests shall be provided prior to the MCSCs medical necessity and covered benefit review to afford the MTF the opportunity to see the patient prior to any decision.

6.2.4 In instances where the MTF elects to accept the patient, the MTF will advise the MCSC as defined in paragraph 6.2.1. The MCSC will notify the beneficiary of the MTF's acceptance and provide instructions for contacting the MTF to obtain an appointment.

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